A STUDY OF THE FACILITIES AND POLICIES OF THIRTY-TWO PROPRIETARY NURSING HOMES AND NON-PROFIT CONVALESCENT HOMES SERVING RESIDENTS OF GREATER NEW YORK

A THESIS

SUBMITTED TO THE FACULTY OF THE ATLANTA UNIVERSITY SCHOOL OF SOCIAL WORK IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY

BEULAH RUTH CLARK

ATLANTA, GEORGIA

JUNE 1947

TABLE OF CONTENTS

36

List of Tables

CHAPTER I

INTRODUCTION

Significance of This Study

The Urban League of Greater New York[1] has, for the past thirty years, endeavored to serve the people of the community by opening up new opportunities and by stimulating interest in many areas pertaining to the general welfare of the Negro.[2] The health program takes its place among the many other programs which are conducted by the Urban League in order to achieve this end.

> The League's health program is designed toward creating positive action in raising health levels among the Negro population of Greater New York. Under the supervision of a specially organized health committee, and the League's Health Secretary, its objectives are: the developing, extending and improving of present health facilities and services; promoting new facilities; and encouraging wider health education and research.[3]

An attempt to secure adequate convalescent care for residents of the community has for many years been one of the important tasks of the health committee of the Urban League. Because of the marginal income status of many Negro families,

---

[1]Brooklyn Urban League and New York Urban League were incorporated under this name on July 31, 1944.

[2]"The Urban League of Greater New York, Inc. Its Background and its Future," 1944, (mimeographed) p. 7.

[3]United Urban League Service Fund, Analysis of Programs of National Urban League and Urban League of Greater New York (New York, 1946), p. 19.

illness has often been for this group one of the most baffling problems to be met both from a financial and emotional standpoint. Even after the difficulty of obtaining adequate medical care has been surmounted, families have often found themselves completely unequipped to secure adequate post-illness rest either in or out of the home.[1]

Discriminatory practices which were prevalent in many convalescent homes prior to 1943 also made it extremely difficult for Negroes to receive the much needed out-of-hospital care. In December 1942, however, through Urban League efforts, the Commissioner of Welfare of the City of New York made it compulsory for the convalescent homes receiving public funds to offer their facilities without discrimination.[2]

The advent of this new policy precipitated the establishment of a new service in the Health Department of the League whereby information was gathered and given out to persons desiring placement in a suitable convalescent or nursing home. Referrals and contacts were made upon request. For this reason, the members of the health committee of the League thought it a wise plan to have these homes visited by a worker in the department so that the organization would be able to disseminate first-hand information and impressions.

During March and April of 1946, the writer as a part of a

---

[1] Ibid., p. 20.

[2] Elizabeth G. Gardiner and Francisca K. Thomas, The Road To Recovery From Illness (New York, 1945), p. 27.

supervised work experience was requested to study these homes.

Purpose of This Study

It is the purpose of this study to present a picture of services available to persons needing out-of-hospital care. In addition, some of the facilities offered in the various homes will be described, and an analysis of the need for this type of service to residents of the community will be made.

The ultimate purpose of the study will be to facilitate the selection of either type of home by the Health Department of the Urban League of Greater New York for persons desiring placement. The League will take into consideration the patients' individual needs and will make suggestions in consideration of the data presented in this study.

Scope and Limitations

Included in this study are thirty-two homes in New York State and Connecticut which provide either nursing or convalescent care for residents of Greater New York. Seventeen of these homes are classified as proprietary nursing homes, and fifteen are classified as non-profit convalescent homes.

Due to the nature of the study which was made primarily for the purpose of reviewing the social conditions existing in the several homes, it is, therefore, limited in respect to the inclusion of extensive materials concerning policies and facilities.

Method of Securing Data

The homes studied were chosen at random from two sources.

One source was a list of Private Proprietary Nursing Homes obtained from the Department of Hospitals and compiled by the General Inspector's office in New York City in January 1946. The other source was a list of Homes providing Convalescent opportunities for Negro Patients compiled by the New York Urban League in June 1943.

A schedule was prepared to be used in conducting personal interviews with the directors of the various homes. A personal visit was made to the homes at which time the directors were interviewed, schedules were filled out, and opportunity was given to observe the building and the activities of the patients.

For further factual data and interpretation of findings, documentary materials in the area of convalescent and nursing home care were consulted.

Definition of Terms

Throughout this report, the term nursing home will be used in place of the words Proprietary Nursing Home. The term will be used to designate a home for the care of ill, aged, or chronic patients. The home is operated under private ownership primarily for profit or for financial gain.

The words convalescent home will be substituted for the words Non-Profit Convalescent Home. As used in this report, the term is defined as follows:

> . . . . an institution for the care of patients during a period of recovery after a period of illness, giving some health supervision, and incorporated not for profit under the management of a responsible board of public-spirited citizens. The institution may charge a fee

for its services but does not attempt to maintain itself entirely from fees.[1]

[1]Elizabeth G. Gardiner, Convalescent Care In Philadelphia (Philadelphia, 1939), p. 2.

CHAPTER II

PHYSICAL FACILITIES

Location and Accessibility

The nursing homes included in this study were distributed in four boroughs of New York City. Five homes were located in Manhattan, five were located in Brooklyn, five in the Bronx, and two in Queens. All of the seventeen homes were located in residential areas, and were conveniently reached by means of public transportation.

The location of one of the nursing homes was considered undesirable. The almost constant stream of traffic which passed this home in going to and from the Westside driveway made it impossible for the patients to enjoy the quiet and pleasant surroundings which are so helpful to persons who are trying to regain their health.

The convalescent homes visited were more widely scattered in location. Three of the homes were situated in residential areas within the New York City limits. The remaining twelve homes were located in suburban areas of New York State or of Connecticut. All of the convalescent homes, however, were easily accessible to residents of Greater New York by railway, bus or automobile.

Equipment of Grounds

None of the nursing homes was surrounded by any appreciable

amount of open space or landscaped ground. The largest amount of such surrounding ground, estimated as being approximately thirty-five feet by fifty feet, was an adjunct to one of the homes located in Queens.

The amount of land used by the convalescent homes varied from a minimum of one city lot (29½ feet by 100 feet) to a maximum of 220 acres. It is important to note, however, that the home which was limited in size to one city lot had the advantage of being situated opposite a beautiful part which the patients visited at convenient times during the day.

The land surrounding the convalescent homes was attractively landscaped and well planned for the convenience and enjoyment of the patients. Seats were located in appropriate places on the grounds of all of the homes, playgrounds were provided in each of the children's homes, and various kinds of equipment for outdoor recreation such as outdoor fireplaces and picnic grounds were provided in many of the adult homes. In all instances, the grounds included level paths so that the patients migh enjoy leisurely walks as a means of exercising and regaining their health.

The Buildings

The interviewer's impressions regarding the attractiveness of the buildings were based on the apparent general upkeep. This included such things as the visible state of repair, painting, and cleanliness of window panes and curtains.

The outer appearance of the nursing homes - all of which

were either of brick, stucco, or frame construction - varied in degrees of attractiveness. Four of the buildings were classified as unattractive. In comparison to this, the outer appearance of one of the Brooklyn homes was considered to be exceptionally attractive. Three other homes, located in Manhattan and the Bronx, were recorded as being very attractive. The remaining nine homes appeared to be average buildings of moderate attractiveness.

The height of the buildings ranged from two stories in three homes to seven stories in one of the larger homes. In compliance with the regulations from the Department of Hospitals, each of the nursing homes over twenty feet high was reported to be either completely fireproof or equipped with adequate fire extinguishers.[1]

Steps and all other energy consuming devices should be minimized in the planning of a nursing home because of the physical inadequacy of the patient in need of nursing home care.

The number of steps at the front entrance of the nursing homes did not exceed nine in the majority of cases. The one home, however, in which this figure was surpassed required all patients or other persons entering the building to ascend thirty steps. This excessive number of steps seemed to show a lack of foresight in planning or a lack of consideration of the physical ability of the prospective patients.

---

[1]City of New York Department of Hospitals, Regulations Governing the Establishment and Maintenance of Private Proprietary Nursing Homes, Convalescent Homes and Homes for the Aged or for Chronic Patients (New York, 1942), p. 6.

Nine of the fifteen convalescent homes were rated as being very attractive from the outside. It was noted, however, that the one home of frame construction appeared to be rather unattractive and in need of re-painting and repair. The other home which was considered unattractive from the outside was one which was located within the limits of New York City. Three homes were classified as attractive, and one was considered to be exceptionally attractive.

Three of the convalescent homes utilized the cottage plan of building arrangement. In one of these three homes, there was no form of covered passage-way between buildings. This was considered poor planning since the patients' meals were served in the main building. Patients, therefore, were compelled to go out-of-doors in inclement weather for meals and several other forms of group activity.

The number of steps at the front entrance of the convalescent homes varied widely. The ideal situation existed in one home in which there were no steps at the front entrance. Patients were therefore not required to expend needless energy in stair climbing upon their entrance to a home in which they were to be aided in recovering to a state of health. The maximum amount of steps at the front entrance of the homes studied was found to be fourteen. This problem of numerous steps at the front entrance of a convalescent home is a great one for a newly arriving patient because it tends to make him more fatigued after having had a very tiresome trip to the home.

Dormitory Facilities

A sufficient number of beds was provided in the seventeen nursing homes to accommodate 621 patients. The total bed occupancy on the day the homes were visited was 526. The distribution of these beds according to boroughs was as follows: 359 in Manhattan of which 285 were occupied; 117 in Brooklyn of which 102 were occupied; 104 in the Bronx with the bed occupancy of ninety-eight; and forty-one in Queens all of which were occupied. Table I shows the distribution.

TABLE I

BED CAPACITY AND BED OCCUPANCY OF NURSING HOMES BY BOROUGHS
(March - April 1946)

Borough	Number of Homes	Bed Capacity	Beds Occupied
Total	17	621	526
Manhattan	5	359	285
Brooklyn	5	117	102
Bronx	5	104	98
Queens	2	41	41

Although all of these seventeen homes had private room facilities, only two of them accommodated each patient in a private room. In one home there were as many as ten persons in one ward, but in most homes there were no more than five patients in one room. In all cases, the number of windows was considered adequate in comparison to the number of persons per room.

It has been observed that the condition of the walls in a room have a definite psychological effect on the ill or convalescent patient. Clean walls decorated in soft pastel shades, are to be desired since they tend to lend a quiet attractiveness and a homelike and cheerful atmosphere to a room.

Wall colorings in the rooms or wards of the nursing homes were varied. Eight of the homes had all of the rooms painted in a light cream color; in two homes the rooms were painted light greem; in three homes the rooms were all rose; in one home some of the rooms were light cream and the others were light blue; and in one home most of the rooms were painted white and the remaining ones were decorated in a floral designed paper with a white background. Rooms in nine of the homes were painted in 1946 and, of the remaining eight homes, date of last painting went as far back as 1943.

Beds were situated on the main floor as well as on the upper floors in fifteen of the nursing homes. In the remaining two homes the beds were located above the main floor.

The fifteen convalescent homes included in this report had a total bed capacity of 1144 of which 567 were for adults. and 577 were for children. At the time the homes were visited, the beds were occupied by 450 adults and 499 children giving a total bed occupancy of 949. Of the fifteen homes, six accepted men and women patients, two accepted men, women and children,[1] two accepted women and children, four were for children

---

[1]Children's activities and provisions are not being reported on for one of these two homes since children are accepted only during summer months.

only, and one was for women only.

TABLE 2

BED CAPACITY AND BED OCCUPANCY OF CONVALESCENT HOMES
(March - April 1946)

Patients Accepted	Number of Homes	Bed Capacity	Bed Occupancy
Total	15	1144	949
Men and women	6	350	254
Men, women and children	2	134	98
Women and children	2	224	187
Women	1	22	16
Children	4	414	394

Doctor E. H. Lewinski-Corwin recommends that it should be the policy of each convalescent institution to provide single or double rooms for adults. He also says that in no case should the rooms hold more than four persons. Children's dormitories also should have only a few beds in each ward.[1] In only three of the eleven adult convalescent homes, however, were there any accommodations for single rooms; but even these three homes maintained four and five bed wards as well as the single and double rooms. In addition to these three homes seven provided double room accommodations for a comparatively small number of

[1] E. H. Lewinski-Corwin, Institutional Convalescence Standards for the Care and Management of Convalescent Homes, (New York, 1925), p. 4.

patients. The maximum number of beds in a ward for adults was fourteen. The number of beds in a dormitory for children ranged from a minimum of two in one specialized home to a maximum of twenty-four in another home.

The walls of the bed rooms in six convalescent homes were painted in various pastel shades. In one other home the director preferred to have the wall colorings described as "rainbow colors". All of the rooms in five homes were painted in a light cream color, while in two instances a few rooms were painted light cream and the remaining rooms were painted light green or some other pastel shade. Wall paper of many restful designs was used in the bed rooms of one of the best-equipped homes.

The date of last painting of the bed rooms was as far back as 1942 in one convalescent home, and 1943 in another; but despite the pressure of war-time shortages, it was noted that three homes had been painted last in 1944, five in 1945, and five in 1946.

In only one convalescent home were patients' beds located above the third floor. Seven homes provided beds on the third floor or below, and in six homes the patients' beds were located on the first and second floors only. The ideal arrangement of bed floors was found in one home for cardiac children in which all beds were located on the main floor.[1]

---

[1]Elizabeth G. Gardiner and Francisca K. Thomas, op. cit., pp. 54 - 56.

Elevator Service

Of the ten nursing homes which maintained patients' beds on or above the third floor, six were equipped with elevators for the use of the patients. It was surprising to note, however, that there was no elevator in one of the Brooklyn homes in which beds were located on the first five floors. This latter finding should be of great concern to the City Department of Hospitals since the patients in this home were expected to have their meals three times a day in the main floor dining room. At present the Department of Hospitals, in its regulations governing nursing homes, has no regulation requiring the installation of elevators regardless of the number of stories of the building.

The elevator situation in one of the convalescent homes was also incredible. Patients whose beds were situated on the four floors of the home were expected to participate in activities, such as meals and recreation, on the main floor. Five of the seven convalescent homes which provided patients' beds on the third floor or below were equipped with elevators, and two of the six homes with beds only on the first two floors provided elevators for patients' use.

Isolation Facilities

Every nursing home is required by the regulations governing them as set up by the City Department of Hospitals to have "at least one room provided for the isolation of cases of communicable disease. This room shall be fully equipped for

carrying out a proper isolation technique."[1] It was noted during the visits to the seventeen nursing homes that fourteen of the proprietors failed to provide any kind of isolation facilities for patients with contagious diseases or infections. In the three homes in which the directors stated that isolation facilities were provided, they were not completely adequate since in no case was the one room which was set aside for this purpose "fully equipped to carry out a proper isolation technique."[2]

Isolation facilities were completely lacking in three of the convalescent homes which accommodate adults only, despite the fact that for the safety, protection and well-being of the patients, every convalescent home should provide complete and adequate units for the isolation of infected persons. Two homes which accepted adults and children provided isolation units for the children but no isolation provisions were made for adults. The remaining ten homes did have isolation facilities, although in a few cases the units were not completely equipped.

All of the convalescent homes which accommodate children provided isolation rooms for them. There need be little or no concern, therefore, about the communication of infectious disease among children in convalescent homes. Such provisions for adults, on the other hand, should be taken into consideration

---

[1]City of New York Department of Hospitals, op. cit., p. 8.

[2]Ibid.

since they were lacking in five of the eleven adult homes studied.

Toilet and Lavatory Facilities

It was found that the regulations of the City Department of Hospitals were not being enforced regarding toilet facilities in two of the nursing homes visited. These regulations state that "there shall be a ratio of at least one toilet for every eight patients."[1] One of these two homes, having a very large bed capacity, provided one toilet for an average of nine and three tenths persons. The other home to which reference is made, provided a ratio of one toilet for an average of eight and eight tenths persons. While this latter differs only a small percentage from the stated regulation, it is, nevertheless, significant to note that this regulation is not being enforced. It is significant because it is felt that the regulation itself represents a rather minimum standard.

The remaining fifteen homes varied as to the ratio of the number of patients per toilet with the figure ranging from two and two tenths persons per facility in one home to exactly eight persons in another home.

The regulations[2] state that there shall be a ration of at least one tub or shower for every twenty patients. It was found in visiting the homes that in only one case was this.

---

[1] Ibid.

[2] Ibid.

regulation disregarded. In the one home to which reference is made, there was only one tub and no showers for a total bed capacity of thirty-five patients. The director of this home made an attempt to justify this condition by stating that most of the patients were either too old or too ill to take a tub bath or shower.

In the sixteen homes which did conform with the regulations, the ratio of the number of patients to the number of tubs and showers ranged from an average of one and nine tenths persons to an average of thirteen and three tenths persons. In comparison to the standard this appears to be a desirable range.

Because of the inability of the person in charge to remember the details, no data were received in regard to the number of toilets, tubs and showers in two of the children's convalescent homes and in the children's division of one of the convalescent institutions which housed both adults and children. Data received from the remaining convalescent homes indicated that, in general, there was no obvious difference between the number of toilets and lavatory facilities provided for adult use as compared to those for the use of children.

The information obtained from thirteen adult convalescent homes revealed that the ratio of the number of patients per toilet or urinal ranged from an average of two and one tenths in one home to an average of seven in another home.

Showers and tubs were found to be adequately provided in eleven of the thirteen convalescent institutions. The home best equipped in this respect provided one tub or shower for

every four patients. The two homes which were considered inadequately equipped provided one tub or shower for an average of fourteen persons and eighteen and three tenths persons respectively.

Summary.--The seventeen nursing homes, each surrounded by a limited amount of ground, were situated in easily accessible residential areas of four boroughs of New York City. Most of them were considered moderately attractive in outside appearance. Although the number of steps at the front entrance varied considerably, only one building had an excessive number of steps.

Private rooms for patients were available in each nursing home and in most instances there was a maximum of no more than five patients per room. Isolation facilities were almost completely lacking in many of the homes whereas elevator service for patients was, in general, adequate.

The regulations of the City Department of Hospitals which relate to toilet and lavatory facilities were disregarded in a comparatively small number of nursing homes. In contrast to this, however, the remaining private institutions provided a sufficient number of toilets and lavatory facilities in proportion to the number of patients served.

The fifteen convalescent homes were located, for the most part, in suburban areas of New York State and Connecticut and were within easy reach of New York City. Most of the homes were classified as attractive buildings situated in spacious, beautifully landscaped surroundings. The cottage plan of

building arrangement used in one home was considered unsatisfactory inasmuch as there was no covered passage-way between buildings.

Specification was made as to whether the convalescent homes admitted men, women or children or a combination of these groups. The children's homes, however, accommodated an average of more patients per room than did the adult homes; but on the other hand, children's homes provided more complete facilities for isolation than were provided in homes for adults. Elevator service was fairly adequate, and toilet and lavatory facilities were sufficient in comparison to the patient population.

CHAPTER III

PROVISIONS FOR MEALS

Types of Meal Service

Tray service was the most prevalent type of meal service in the nursing homes. This was the only kind of service in fourteen of the homes from which data were received. The remaining three homes provided dining room service for persons desiring it; but tray service was given to those who were either too ill to go to the dining room, or to patients who, for any other reason, did not wish to take their meals in the dining room.

The dining room was situated on the main floor of each of the three nursing homes providing such facilities. In these three homes both males and females were seated at the same table for meals, thus providing a home-like, family atmosphere at meal-time.

In contrast to the very noticeable absence of dining room service in the majority of the nursing homes studied, all of the fifteen convalescent homes provided dining rooms for patients' use. The directors in most of the adult convalescent homes, however, stated that tray service was sometimes given to a patient in case of an emergency. Two of the specialized children's homes provided bed trays regularly for a few children who suffered from cardiac conditions or from Rheumatic

fever.

The dining rooms in all of the convalescent homes were attractively arranged with from four to eight seats at each table. Adult males and females were seated in the same dining room in six of the eight convalescent institutions which cared for both sexes; two of these homes permitted both males and females to sit at the same table for meals, while in the other four institutions, males and females sat at separate tables in the same room. The reason given for this separation by the directors was the same in each case. The directors were of the opinion that the patients would not eat as heartily if they were in the presence of patients of the opposite sex. This they thought might be due either to the excessive amount of conversation which is inevitably engaged in when males and females are seated at the same table, or to the bashfulness or shyness of one sex in the presence of the other. This was also the reason given for the maintenance of separate dining rooms for men and women in two of the adult homes which admitted both sexes.

An analysis of the seating arrangement in the dining rooms in the seven children's convalescent homes showed that in three homes, boys and girls sat at the same tables; in three homes, both boys and girls sat in the same room but at separate tables; and in one home, boys and girls ate in different dining rooms. Again the reason given for this separation of the sexes was the belief that the children would tend to do more playing than eating if boys and girls were seated at the same dining table.

Nutrition and Diet

Although nutrition and diet are closely related, there is a fundamental distinction between the two. Dr. H. D. Kruse of New York maintains:

> Nutrition as a term, aside from being confused with diet, has been used to convey several different ideas. It is preferable to return to its original concept, that it is bodily process. Diet, on the contrary, comprises the foodstuffs which are consumed for use in the body. It supports the bodily process.[1]

The nutritive needs which must be supplied by food include a list of substances of a chemical nature which are indispensible in the diet to health.[2] It can be seen, therefore, that nutrition is a more inclusive and a more complex term than diet.

When considering the nutritive essentials for persons in either a nursing home or a convalescent home, one should rightly consider the needs of each patient to be served. One should take into consideration the patient's age, size and sex in addition to the essentials required to restore the individual who has suffered or who is suffering from a certain type of illness to an adequate state of health and strength.

A well organized system of nutritive therapy, therefore, should be indispensible in the organization of an adequately equipped and well planned nursing or convalescent home.

> Nutritive therapy has no one standardized formula applicable to all situations; in its details it varies with the patient. What is to be done depends on what conditions

---

[1]The New York Academy of Medicine, Convalescent Care (New York, 1940), p. 16.

[2]Ibid., p. 17.

have been found in the particular individuals.[1]

Since all illnesses and diseases involve an impaired nutritive state, patients in nursing and convalescent homes might well be grouped together according to the underlying type of disease. This method of procedure was used in specialized types of homes such as homes for children with rheumatic fever or for persons with cardiac conditions. After a diagnosis of the nutritive condition has been made, provision for an adequate diet should then be made, based upon the particular nutritive essentials of the patient.[2]

One's diet is adequate when it has sufficient calories, proteins, minerals, and vitamins necessary to insure proper body functioning within the individual.[3] The directors of all of the nursing homes visited stated that the patients' meals were well balanced, wholesome, and appetizing. Although samples of the menus for a typical day were supplied by the directors, this was of questionable value since, for this report, no study was made of the patients' menus or personal food needs over a period of time.

Four of the nursing homes made no provisions for the preparation of special diets for patients requiring this service. In light of the knowledge of individual nutritive requirements,

---

[1] Ibid., p. 22.

[2] Ibid., p. 23.

[3] Jennie I. Rowntree, This Problem of Food (New York, 1939), p. 14.

the lack of this service seems to reflect inefficiency and incompleteness of service to patients. In the thirteen homes which did provide special diets to persons needing them, there were fifty-nine persons receiving such service.

Strict Kosher dietary laws were observed for all patients in seven of the nursing homes and in three of the convalescent homes studied. However, although the directors of thesd homes did adhere strictly to their religious laws in regard to kinds of food served, they did not have any restrictions as to the religion of the patients admitted.

All of the directors of the convalescent homes were of the opinion that their patients were served wholesome, well-balanced, appetizing meals. This was not substantiated since only one home submitted a complete week's menu for study. Eight of the fifteen convalescent homes made provisions for special diet for a small number of patients. No home, however, was willing to accept a patient whose diet was extremely rigid. Of the remaining seven homes, two made indirect provisions for special diet by allowing the patients a selection of food at each meal, and two made mention of the fact that although diabetics were not catered to, provisions were sometimes made for helping them to eat the correct foods. The other three homes, two of which were specialized homes for cardiacs and thus provided special foods for all of the patients did not accept patients who required special preparation of foods.

Summary.--Patients were required to take their meals either in bed or in their rooms in fourteen nursing homes since

these homes served meals to patients by means of tray service only. In the remaining three homes, although a dining room was provided on the main floors in which meals were served in an attractive and cheerful atmosphere, preference was generally given to patients as to whether they would take their meals on a tray or in the dining room.

All of the convalescent homes gave dining room service almost exclusively, with tray service being given only in cases of emergency. Attractive dining rooms were arranged with tables seating from four to eight persons. Only two adult homes and three children's homes permitted males and females to sit at the same tables. Males and females were separated in the other homes so that they might eat more heartily.

The directors of all nursing homes and convalescent homes stated that the patients' meals were wholesome and well-balanced. However, since a well organized system of nutritive therapy takes into consideration the individual patient and his dietary needs in relation to his physical condition, the four nursing homes which made no provisions for special diet were considered inefficient in this area. A total of fifty-nine patients were on special diet in the thirteen homes providing this service. Several of the convalescent homes were willing to prepare special diets which were not too rigid.

Strict Kosher dietary laws were observed in seven nursing homes and in three convalescent homes.

CHAPTER IV

RECREATION AND SOCIAL PLANNING

Indoor Activities

The role of the nursing home or of the convalescent home is

> . . . . not only to supply the necessary physical elements to bring the patient to the highest level of efficiency, but to develop such wholesome emotional attitudes that relapse is adverted. General recreation and play therapy are two of the modern means of untangling the emotional problems.[1]

Dr. Adrian V. S. Lambert states that if facilities for the entertainment and amusement are not provided for the patients, they readily fall into groups, talking about themselves, their ailments, their hospital experiences and their troubles. This he says is the worst possible atmosphere in which to regain health. Dr. Lambert further states that in such institutions, supervised leisure should be required so that the patients will not have time for idleness.[2]

Recreational facilities were found to be very limited in all of the nursing homes from which information was received. Four of the homes provided no common recreation or sitting room for the use of the patients. One common reading room, reception

---

[1]Elizabeth G. Gardiner and Francisca K. Thomas, op. cit., p. 103.

[2]E. H. Lewinski Corwin and Thomas B. Kidner, Standards for Convalescent Homes Policy - Organization - Planning (New York, 1930), p. 4.

room or sitting room was provided in each of ten homes; two such rooms were provided in each of two homes; and three common rooms were provided for patients' use in one home.

Of the seventeen nursing homes visited, six did not provide a radio for the use of the patients. Patients in five of these six homes, however, were permitted to have their own radios if they so desired. In ten of the remaining eleven homes, at least one radio was provided in the home for the patients' use. One of these ten homes provided a radio in every room. Another nursing home had a music box installed in the building with a loud speaker placed on each floor. Although no radios were permitted in this latter home, the patients were entertained at regular intervals throughout the day.

Books, magazines, and newspapers were supplied for patients' use by each of twelve nursing homes. The remaining five homes made no attempt to make provisions for the entertainment of patients in this area. In each of these five homes, however, patients were given the privilege of supplying their own reading material.

Group participatory activities or supervised occupational therapy were completely lacking in any of the seventeen nursing homes.

It is not expected that persons in a nursing home will be very active, but there are many varieties of inactive games or other forms of recreational activities in which the ambulatory patients could participate. Recreational relaxation and occupational therapy have been proved to be advantageous in the

total treatment of patients who are confined to hospitals or other institutions for the physically ill.[1] For this reason, it was believed that the nursing homes included in this study were not utilizing the maximum possibilities in the area of patient recreation and participation.

"A patient recovering from illness needs freedom to join in the normal activities of social life and equal freedom to withdraw from them at intervals for rest."[2] With this statement in mind, it was felt that the recreational facilities provided in the convalescent homes were, on the whole, fairly adequate for the relaxation of the patients. Despite this general conclusion, it was noted that the number of common rooms was inadequate for the patient population in most of the homes. The average number of patients per common room ranged from a minimum of seven in one home to a maximum of eighty in two homes. In nine of the fifteen homes there was an average of twenty-two or more persons per common room.

Each of the convalescent homes provided at least one kind of musical instrument or radio for the patients' use. One children's home provided a radio in each dormitory in addition to two pianos and a victrola. Group singing was reported to have been an occasional source of recreation in some of the homes.

---

[1]William Rush Dunton Jr., Occupational Therapy A Manual for Nurses (Philadelphia and London, 1918), pp. 24 - 33.

[2]Elizabeth G. Gardiner and Francisca K. Thomas, op. cit., p. 57.

Although no figure was obtained as to the number of books in the library of each home, or the kind of books supplied, it was evident that each of the fifteen convalescent homes maintained a supply of books and other reading material for the convenience, relaxation, and education of the patients.

Special entertainment activities such as movies, musical programs, and parties were provided at intervals in a few homes. Supervised occupational therapy was provided in all of the seven children's homes as compared to its use in only three of the eleven homes which accommodated adults.

Outdoor Activities

Seats situated on a porch, on a lawn, in a back yard, or in a garden were the extent of the outdoor recreational facilities provided in eleven of the seventeen nursing homes. Patients in one home were permitted to go out for walks if they were strong enough for this kind of activity; these walks were taken either by the patient alone or with visitors. Four homes provided no facilities for outdoor recreation for the patients.

The considerably large amount of ground surrounding the convalescent homes facilitated the planning of outdoor recreation. In addition to a wading pool in one of the homes for children, and two outdoor craft cottages in another, each of the children's homes provided a well equipped outdoor playground. For adult use, two homes provided croquet sets, one provided a beach for summer recreation, and one made provisions for outdoor picnics. All of the homes permitted the patients to take

walks within certain designated bounds on the grounds. Seats were situated conveniently on the grounds for the relaxation and comfort of the patients.

Summary.--Both indoor and outdoor recreational facilities and occupational therapy were noticeably inadequate in the nursing homes in spite of the opinion of Dr. Adrian V. S. Lambert who states that sufficient recreational activities should be provided in these homes so that patients will not have too much time to think about their physical ailments and troubles.

Although a sufficient number of common rooms for patient use was not provided in most of the convalescent homes, indoor recreational facilities were fairly adequate in these homes. Musical instruments, radios, and books were provided in each home and group entertainment activities such as group singing, movies, and parties were carried on in a few homes at intervals. Supervised occupational therapy was a part of the regular patient activity in all of the children's homes and in three of the adult convalescent homes. Outdoor recreational activities and facilities were adequately provided in the fifteen convalescent homes.

CHAPTER V

DESCRIPTION OF PATIENTS

Age and Sex

When this study was made in 1946, the age, sex and other identifying information relating to the patient population of the two types of homes were noted. Of the 526 beds occupied in the nursing homes, 150 were occupied by males and 376 by females. Despite this disproportionate figure, only one nursing home with a total bed capacity of fifteen and a total patient occupancy of twelve was reported to accept females only.

The figures obtained from the convalescent homes showed that of the 450 adult admissions, there were 154 men and 296 women. The 499 beds used by children were occupied by 182 boys and 317 girls.

Age was not a factor in the determination of patient admissions in any of the nursing homes; however, a study of the age range of the patient population at the time the nursing homes were visited revealed that 495 persons were sixty years of age or over. The results of the study further revealed that thirty patients were between the ages of forty and fifty-nine, and only one patient was in the age range between twenty and thirty-nine years.

The age range of patients admitted varied from one children's convalescent institution to the other. Girls were

accepted up to the age of sixteen in two of the seven children's homes, and up to the age of fifteen in three other homes. Two homes admitted girls up to twelve years of age. The general trend noted in the children's homes was that boys have less chance of placement than do girls. Only one home accepted boys up to the age of fifteen, and this was a specialized home admitting only those children who were convalescing from rheumatic fever. In addition to this one home, two admitted boys up to the age of twelve, two admitted boys up to the age of ten, one accepted boys up to nine years of age, and one home made no provisions for boys who were over six years old. Although one home accepted babies one year old or over, and two homes accommodated children two years of age and over, it was found that one institution did not admit children under five, and three homes did not admit children under six years of age.

The study of the age range of adult patients in the convalescent homes revealed that on the day the respective homes were visited, there were eight adults between the ages of sixteen and nineteen years, ninety-six patients in the age range between twenty and thirty-nine years, 214 patients between forty and fifty-nine years of age, and ninety-five patients over the age of sixty. No record of the age of patients was received from one convalescent home which had a total bed occupancy of twenty-seven adults.

Since most adult convalescent homes admitted patients who were over sixteen years of age (eighteen years in two homes, and twenty-one years in another home) there is an indication that

There is a definite lack of placements in convalescent insitutions for older children. This is especially true for boys between twelve and sixteen years of age.

Racial Distribution

Lester B. Granger, in discussing convalescent opportunities for Negroes at the Conference on Convalescent Care held under the auspices of the Committee on Public Health Relations of the New York Academy of Medicine,[1] stated:

> Although the Negro is in greater need of facilities for convalescent care than the white person, practically no steps have been taken in recent years to increase the admittedly inadequate facilities available to him.[2]

Mr. Granger indicated that the Negro has a greater need for these services because of the disproportionate amount of illness among the group, and also because the income status of Negroes is far below that of white people.[3] He suggested, in view of the poverty in which the average Negro lives, that community provisions for convalescent facilities for him are necessary from two directions:

> . . . . he cannot pay for convalescent care as readily as other citizens and he is driven to use the over crowded hospitals of highly congested areas where there is a tendency to push out patients before they have completely recovered.[4]

Further evidence of the difficulty which the Negro faced

---

[1]November 9 and 10, 1939.

[2]"Convalescent Care", op. cit., p. 209.

[3]Ibid.

[4]Ibid.

in 1939 when desiring placement in convalescent institutions is indicated by the following statement:

> Particular emphasis was placed by practically all of the social service departments on the difficulty of placing Negro patients. The lack of beds for Negro men was described by most of the directors as an outstanding need. The inability to find convalescent facilities for these patients frequently complicates their medical care. While there is some possibility of placing Negro women, it is on a very limited basis. One hospital reported that a convalescent home would accept a Negro "if he was light-colored." Another reported that two convalescent homes which previously had accepted Negro Women were recently rejecting such applications. There is considerable evidence both in these reports and through other sources that New York City suffers from an almost total absence of facilities for colored adults.[1]

By 1943, however, the convalescent homes serving the New York area had liberalized their admission policies with relation to Negroes[2] primarily as a result of the efforts of the New York Urban League.

> Several of the convalescent homes had more liberal admission policies for "other colored" patients than for Negroes. In a number of cases, however, whether or not the person might be considered a Negro appeared to be the factor determining his acceptance or rejection. For example, in several instances it was stated that Puerto Ricans would be accepted if light in color. One home reported that it would accept only light Puerto Ricans, but would admit Filipinos even if dark-skinned.

All of the fifteen convalescent homes visited admitted patients of any color or race. However, one adult home which had been opened only a few months prior to the date of this study

---

[1] "Convalescent Care," op. cit., pp. 201-202.

[2] Elizabeth G. Gardiner and Francisca K. Thomas, op. cit., p. 27.

[3] Ibid.

had not yet received applications from other than white patients. Figures received showed that there were 854 white patients, seventy-seven Negro patients, sixteen Puerto Ricans, one Chinese patient, and one Indian patient. A further breakdown of the seventy-seven Negro patients disclosed that ther were fifty-seven Negro children and twenty Negro adults.

The proportion of the number of white patients to the number of non-whites in the nursing homes was rather remarkable. It was noted that of the 521 beds occupied, 509 were occupied by white patients, twelve were occupied by Negroes, and five were occupied by patients of other races. In answer to the question of the acceptance of Negro patients, the director of only one nursing home with a total bed capacity of twenty-six stated definitely that she would not admit Negro patients. It was learned, however, that eleven of the homes had never had Negro Patients. (See Table 3)

TABLE 3

RACE OF PATIENTS IN NURSING HOMES AND CONVALESCENT HOMES
March - April 1946

Patients	Nursing Homes	Convalescent Homes
Total	521	949
White	509	854
Negro	12	77
Other	5	18

Religious Affiliation

Data relating to the religion of the patients were not obtained from one of the nursing homes with a total bed occupancy of thirty-two since, according to the director, this home kept no record of the patients' religion. From the remaining sixteen nursing homes it was reported that 307 patients were Jewish, 116 were Protestant, sixty-five were Catholic, and one patient was of no particular religious faith. With the exception of one Brooklyn home with a patient capacity of twenty-one, the directors of all of the homes stated that patients of any religion would be admitted since religion was not an important factor. The director of the home in Brooklyn stated definitely that patients of the Jewish religion would not be accepted in the home.

In regard to the religion of the patients in the convalescent homes, no record was obtained from two homes which had a total bed occupancy of eighty-three. In the remaining thirteen homes there were 415 Catholic patients, 278 Jewish patients, 168 Protestant patients, and five patients of other religions. (See table 4)

TABLE 4

RELIGION OF PATIENTS IN NURSING HOMES AND CONVALESCENT HOMES
March - April 1946

Patients	Nursing Homes	Convalescent Homes
Total	521	949
Catholic	65	415
Protestant	116	168
Jewish	307	278
Other	1	5
No record	32	83

Diagnoses of Patients

The nursing homes varied in respect to the types of cases they would or would not accept. Figures, as reported by the licensees of the homes, revealed that there was a unanimous agreement against the acceptance of contagious diseases or mental cases. Tuberculosis was the next highest on the list of illnesses not accepted with seven homes specifying unwillingness to take cases of this sort. Cancer cases would not be accepted in six homes and alcoholics were banned in four. Various other kinds of illnesses were not accepted in some of the nursing homes.

All of the nursing homes accepted patients suffering from old age or chronic illnesses. Patients with heart conditions were admitted in seven homes and diabetic patients were admitted in six. Table 5 describes the complete range of illnesses.

provided for in the various types of homes.

TABLE 5

DIAGNOSES ACCEPTED AND NOT ACCEPTED BY NURSING AND CONVALESCENT HOMES March - April 1946

Diagnostic Classifications	NURSING HOMES		CONVALESCENT HOMES	
	Homes accepting cases	Homes not accepting cases	Homes accepting cases	Homes not accepting cases
Contagious		17		10
Mental Diseases		17		6
Tuberculosis	1*	7		3
Cancer		6		3**
Alcoholics		4		
Parkinson's Disease	3	3		
Abortion cases		2		
Maternity cases		1		1
Amputations	2			
Pediatrics		1		
Fractures	3	1		
Diabetes	6	1	5	3
Multiple - Sclerosis	2	1		
Arterio - Sclerosis	3			
Senile cases	17			1
Heart Conditions	7		10	
Hemiplegia	4		3	
Post-Stroke	5			
Hypertension	2		1	1
Chronic Cases	17			3
Post-Operatives	2		10	
Ulcers of gastrointestinal tract	1		2	
Colostomy			1	3
Malnutrition			4	
Pneumonia			1	
Orthopedics			1	
Diseases of genito-urinary tract				
Upper respiratory infections			4	
Renal Diseases				2
Mild Psychiatric cases			1	
Arthritis				

*First stage only
**Arrested cases of cancer accepted in one of these three homes.

Convalescent homes presented as great a variety of diagnoses which they would or would not accept as did the nursing homes. Although the investigator realizes that the figures received are incomplete because of apparent inability of the directors to recall each diagnosis, the table above gives a general picture of types of illnesses from which patients in the convalescent homes were recovering. The table also gives an indication of the diagnoses which the homes will not accept.

Average Length of Stay

It was extremely difficult to obtain any accurate information regarding the average length of stay of patients in the nursing homes. Nevertheless, it was evident from the directors' comments, that, although a few patients remained in the homes for as short a period of time as one week, the majority of patients remained over a period of months, and in many cases over a period of years with the intention of remaining permanently until the end of their lives.

The average length of stay of adult patients in the general convalescent homes ranged from two weeks to forty-three days. In the one specialized adult home (cardiac adults) the average length of stay per patient was eight weeks. Convalescent children remained in the general homes for an average of six weeks and in the two specialized homes (cardiac and rheumatic fever conditions) for an average of 320 days and sixteen months respectively.

A marked improvement in the flexibility to meet the patient's needs is evident in contrasting the present

> policies with those in force ten years ago. A few homes, however, still have a two limit. Obviously, no two persons recovering from the same illness are going to do it in the same time. Some authorities recommend a three week period with extention of time on the doctor's recommendation. The writer thinks the length of stay can best be fixed by the doctor, who is watching the patient from week to week and has the recommendation of the doctor who cared for the patient during the acute phase of the illness. No lay person should fix the time limit.[1]

Fees Per Patient

The fees per patient in the nursing homes varied from one home to the other. Whereas the fees in one home ranged from $90 to $125 per month, fees in another nursing home ranged from $40 to $100 per week. The directors in nine of the homes stated as their minimum fee $35 or more a week. In eleven of the nursing homes the maximum fee charged a patient was $50 or more a week. In each home the fee for a given patient depended upon the individual patient, his or her illness, and the amount of care and attention required by the patient.

Because of the several sources of income of the convalescent homes, the fees per patient were comparatively small in relation to the types of care given. Five of the convalescent homes rendered free care to all of the patients, and five other homes provided free care to patients who were unable to pay. Although the maximum weekly fee in two of the convalescent homes was $25, the fees in all of the homes were based primarily upon the patients' ability to pay.

Summary.--Female patients in both types of homes out-

---

[1]Elizabeth G. Gardiner, op. cit., p. 67.

numbered male patients considerably. The proportion of females to males in nursing homes was more than two to one and in the convalescent homes it was almost two to one.

A great majority of patients in the nursing homes were over sixty years of age. The ages of patients in convalescent homes were more varied in range with the majority of adult patients being between forty and fifty-nine years of age.

A study of the age range of children admitted in the various children's convalescent institutions indicated that there is a definite lack of placements for older children - especially for boys between the ages of twelve and sixteen years.

In spite of the great need of Negroes for convalescent facilities, practically no steps had been taken prior to 1943 to increase these facilities. The New York Urban League has been instrumental in liberalizing the policies in many of these homes in relation to Negroes. All of the convalescent homes visited admitted patients of any color, race or religion. The proportionate number of non-white patients, however, was very small.

Racial distribution of patients in the nursing homes was as follows: 509 white patients, twelve Negro patients, and five patients of other races. Despite this disproportionate figure, only one nursing home refused to accept Negroes. Another home refused to accept patients of Jewish faith.

The homes varied in types of cases admitted. However, it was very noticeable that in both nursing and convalescent homes patients suffering from contagious or mental diseases were excluded

Although it was difficult to secure accurate data regarding the average length of stay of patients in nursing homes, it was apparent from the directors' comments that the majority of patients remained in the homes over a period of several months.

The average length of stay of patients in the general convalescent homes for adults ranged from two weeks to forty-three days. Children in general convalescent homes remained for an average of six weeks. Specialized homes for both adults and children reported that patients remained for an average of eight weeks and sixteen months respectively.

Fees in the nursing homes ranged from $90 per month to $100 per week. The fees in the convalescent homes, on the other hand, were comparatively low based on the patients' ability to pay.

CHAPTER VI

ADMINISTRATION AND PERSONNEL

Governing Body

Ten of the nursing homes were under private ownership and were governed without the assistance of any form of advisory board. The licensee in each of these homes had absolute authority within the limitations of the standards set up by the Department of Hospitals of the City of New York. This City agency has jurisdiction over the licensing and regulating of all nursing homes within the city.[1] The proprietors of the remaining seven homes stated that a board of directors or a similar type of board, consisting of from three to six members was consulted at periodic intervals in the interest of maintaining an adequately operated home.

The New York State Board of Social Welfare and the Department of Hospitals of the City of New York have the power of visiting and inspecting convalescent homes incorporated within the area included in this study. No conflict arises as to the function of the two agencies since it is the duty of the State Board to establish rules relative to standards of care, buildings, equipment and records whereas the City Department is

---

[1]City of New York Department of Hospitals, op. cit., p. 3.

interested primarily in the medical standards of the homes.[1]

Each of the convalescent homes was governed by a board of directors or by a similar board with the membership ranging from five in one home to ninety in another home. These various boards met at regularly stated intervals for the primary purpose of determining the policies of the institution in addition to seeing "that proper professional standards were maintained in the care of the sick."[2]

Financial Support

In sixteen nursing homes studied, the proprietor stated that the only source of income for the home was from patient fees. Subsidies and endowments constituted other channels of income in addition to patient fees in the one remaining home.

Sixteen nursing home proprietors refused to give information concerning the approximate annual income and annual expenditures of their respective homes. The one home from which figures were obtained, having a total bed capacity of thirty-five, reported an annual income of approximately $35,000 and annual expenditures of approximately $25,000.

Sources of income in the convalescent homes were varied. Aside from the very reasonable patient fees, each home obtained financial support from one or more of eleven other sources viz., gifts and voluntary contributions, legacies and endowments,

---

[1]Elizabeth G. Gardiner and Francisca K. Thomas, op. cit., p. 36.

[2]Ibid.

funds from incorporations, church donations, members' fees, city subsidies, New York City Mission Society, Greater New York Fund, United Hospital Fund, American Hospital Association, and the New York State Department of Social Welfare.

Corwin and Kidner are of the opinion that there is a continuous need for forward strides in the area of convalescent management. In order to facilitate the fulfillment of this need, therefore, they suggest that there is a strong likelihood that "increasingly larger investments, both philanthropic and municipal, will be made in convalescent institutions."[1]

Figures received from six of the fifteen convalescent homes indicated that five of these homes had operated at a loss of from $1,000 to $18,280.28 on patient care in the last year for which figures were available. The one home which reported a profit had a surplus of $2,254.22 in excess of the cost of patient care for the last year for which figures were computed.

Expenditures in any convalescent institution are made for various items in addition to patient care. Funds are needed in order to provide more and better facilities and equipment and, also, funds are needed to pay for adequate professional supervision and efficient personnel.[2] Therefore, in spite of the profit reported in the area of patient care in one convalescent home, it is evident that liberal contributions to these

---

[1]E. H. Lewinski Corwin and Thomas B. Kidner, op. cit., p. 8.

[2]The New York Academy of Medicine, op. cit., p. 212.

institutions from numerous sources are needed in order to attain the highest quality of service.

Professional Staff

> The whole staff should be considered as a team whose members should be persons trained in various fields. If several functions are assigned to one staff member, that person should have the skills and professionally acceptable training essential to carrying out each activity effectively. Time to utilize the skills and to keep informed of developments in each type of activity should be arranged. Every member of the team should have psychological insight and an understanding approach to patients in order to be effective members of it.[1]

Doctors.--Patients in the nursing homes were expected to have their own attending physician. In addition to the visits made by the patients' private physician, six homes maintained at least one doctor who visited the homes at regularly stated intervals in order to check up on the progress made by each patient. Nine homes provided doctors only on call, and one home made no arrangements to provide the service of a doctor for the patients.

Four of the convalescent homes, including one children's home, maintained resident physicians and there were two resident doctors in the home for children and one resident doctor in each of the three adult homes. All of the convalescent homes had doctors who visited the homes at regularly stated intervals. One convalescent institution was reported to have as many as fourteen visiting doctors in addition to a resident doctor.

---

[1] Elizabeth G. Gardiner and Francisca K. Thomas, op. cit., p. 179.

Nurses.--Each of the seventeen nursing homes employed at least one registered professional nurse in addition to the other nurses and attendants. According to information received, it was found that in eight homes the ratio of the total bed capacity to the number of nurses and attendants employed exceeded six to one; in three of these eight homes this ratio was more than ten to one.

Thirteen of the fourteen convalescent homes which supplied information regarding the personnel reported that at least one registered nurse was on the staff. Particular mention was made of the fact that in one adult convalescent home with a total bed capacity of fifty-six there were five registered professional nurses in addition to one relief nurse. The ratio of the average number of patients per nurse or attendant ranged from two and five tenths in one children's home to forty in two adult homes.

Dieticians.--A regularly trained dietician was employed in only two of the nursing homes visited. In two other homes in which the director stated that a dietician was employed, the employee in question had received training, not as a dietician, but as a graduate nurse. The meals in the remaining thirteen homes were planned in eight cases by the directors who were registered nurses, and in five cases by either the cook or by some other employee who had had no special training in dietetics.

Graduate dieticians were employed in four of the fourteen convalescent homes which gave this information. The meals in three of the remaining homes were planned by the superintendents

who, in one case, had taken special courses in dietetics, and who, in the other two cases, were registered nurses. In the remaining seven homes the meals were planned by a lay person who had received no special training for such a position.

Recreational Workers.--There were no trained recreational workers or occupational therapists employed in any of the nursing homes which were studied.

Recreational workers were included on the staff of one adult convalescent home, one children's home, and two homes which accommodated both adults and children. Occupational therapists were employed in five homes; one of these five homes for children employed two occupational therapists. From these figures, it is an indication that supervised recreation and occupational therapy was not being utilized as much as possible as an aid in the total recovery of the patients.

The figures received revealed that, in general, the personnel maintained in the nursing homes was insufficient and inadequate for the purpose of rendering care of high standard to the patients. The definition of a convalescent home states that the persons in such an institution are recovering after a period of illness; therefore, one might consider the medical and nursing personnel employed in these convalescent institutions to be reasonably adequate since patients do not require constant nursing and medical care.

Summary.--Ten of the nursing homes were operated entirely by the licensee without the assistance of an advisory board. The remaining nursing homes were governed by boards consisting

of from three to six members. In contrast to this, all of the convalescent homes were governed by some form of advisory board with membership ranging from five to ninety individuals.

The financial support for the nursing homes was received completely from patient fees in sixteen homes. Subsidies and endowments were the other sources of income in the other nursing homes. The directors of the various convalescent homes reported that financial support was received from one or more of eleven sources. Even with this additional income, however, some convalescent homes were reported to be operating at a loss.

Personnel - including doctors, nurses, dieticians, and recreational workers - was found to be insufficient and inadequate in almost all of the nursing homes studied. On the other hand, medical and nursing personnel in the convalescent homes was reasonably adequate since doctors visited all of the homes at regularly stated intervals and sufficient nurses were employed in all but two adult homes.

Trained dieticians were employed in four convalescent homes, trained recreational workers were employed in four homes, and trained occupational therapists were included on the staffs in five homes.

CHAPTER VII

SUMMARY AND CONCLUSIONS

The information gathered in this study revealed the following data:

1. Seventeen nursing homes visited with a total bed capacity of 621 were located in residential areas of four boroughs of Greater New York. The fifteen convalescent homes, accessible to residents of Greater New York, providing a total bed capacity of 1144 (567 for adults and 577 for children) utilized surrounding ground varying from one city lot to 220 acres.

2. The sleeping rooms in both the nursing homes and the convalescent homes accommodated more patients per room than is advisable in the interests of health and of privacy. The year the homes were last decorated ranged from 1942 in one convalescent home, to 1946 in nine nursing homes and six convalescent homes.

3. Although elevators were installed in many of the homes providing sleeping homes above the third floor, it was noted that there was no elevator in one convalescent home and in one nursing home with patient beds located on the first four and the first five floors respectively.

4. Isolation facilities in most of the adult homes were completely lacking. All of the homes accommodating children, however, did provide units for the isolation of patients with

communicable disease.

5. According to the approved standard of a ratio of at least one toilet for every eight patients, two of the nursing homes were found to be inadequately equipped in this respect. One nursing home, which was far below the desired standard, supplied one bath tub for a capacity of thirty-five patients. Convalescent homes were adequately equipped in regard to both toilet and lavatory facilities.

6. The majority of nursing homes provided only tray service for patients at meal time. The convalescent homes, on the contrary, provided dining room service primarily. Kosher dietary laws were observed in several of the homes under Jewish management. Although few of the convalescent homes made provisions for special diet, most of the nursing homes made such provisions.

7. Recreational facilities - both indoor and outdoor - were more adequate in convalescent homes than in the nursing homes.

8. Many more females than males were patients in the homes. The majority of adults in the nursing homes were over sixty years of age whereas the majority of adults in the convalescent homes were between forty and fifty-nine years of age. There was found to be a definite need for convalescent homes for boys between twelve and sixteen years old. Negro patients were not accepted in one nursing home and Jewish patients were not accepted in another.

9. Diagnoses of patients in both nursing homes and the general convalescent homes varied greatly. No nursing homes, however, accepted patients with either mental or contagious diseases.

10. The average length of stay for most patients in the nursing homes was over a period of months and in many cases over a period of years. Convalescent care for adults was given for an average of from two to four weeks and for children for about six weeks. Specialized homes cared for patients for a longer period of time.

11. Patients' fees made up the only source of income in the majority of nursing homes whereas the convalescent homes received funds from other sources in addition to the relatively small fees from patients.

12. The governing bodies in the convalescent homes were large in comparison to the complete lack of any such body in most of the nursing homes.

13. Although the nursing and medical personnel was considered reasonably adequate in the convalescent homes, similar personnel in the nursing homes was insufficient. Dieticians, recreational workers, and occupational therapists were employed in only a few of the thirty-two homes studied.

Conclusions

On the basis of this study, the writer has drawn the following conclusions:

Nursing Homes:

1. Standards and requirements for licensing of nursing homes should be revised to include such essentials as provisions for elevator service, and a statement of the maximum number of patients per room.

2. All standards set up by the City Department of Hospitals for the licensing of nursing homes should be rigidly enforced. This should be especially true of the requirements for isolation facilities, and for toilet and lavatory facilities.

3. The provision for organized recreational activities and occupational therapy should be of greater concern to the directors of the nursing homes. This type of activity would have definite therapeutic value for the patients.

4. There is definitely a greater need for nursing home facilities having fees within the financial means of persons of the Negro race. Since the average Negro patient is unable to pay the considerably high fees charged in the homes, there is both a disproportionate number of Negro patients in the homes and a disproportionate number of homes which have, at any time during their existence, cared for Negro patients.

5. In consideration of the high standard of service and care expected in a nursing home, there is a need for additional medical and nursing personnel in the majority of these homes.

Convalescent Homes:

1. The New York State Board of Social Welfare whose duty it is to establish rules relative to standards of care, buildings, equipment, and records of convalescent homes should make

the following requirements of the homes in the interest of the patients served:

a. There should be suitable isolation facilities for all patients who may contact a communicable disease. These facilities should be required in adult homes as well as in homes for children.

b. Elevators for the use of patients should be required in all homes.

c. Covered passage-ways should connect buildings if patients are expected to go from one building to another for various activities.

2. There is a need for a wider age range in the children's homes. This age range should be the same for both boys and girls.

3. Patients should be admitted to all homes on the basis of need without regard to race, creed, or color.

4. The length of stay of each patient in the home should be determined on an individual basis rather than on a limited time fixed by the home.

5. A regularly employed trained dietician should be on the staff of each home since nutritive therapy is essential in hastening the physical recovery of the patient.

6. At least one trained occupational therapist and recreational worker should be employed in each home for the purpose of stimulating the patients' interest in various therapeutic as well as recreational activities.

APPENDIX A

LIST OF HOMES VISITED

Nursing Homes

Manhattan	Licensee	Bed Capacity	Beds Occupied
1. Central Park West Nursing Home 22 West 74th Street	Mr. Irwin Polk	50	26
2. Dresden Nursing Home 42 West 74th Street	Mrs. Lucille B. Howard	97	84
3. Golden Convalescent House 417-419 Pleasant Avenue	Mr. Nathan Golden	37	19
4. Lynwood Nursing Home 306 West 102 Street	Mr. William Marquette	35	32
5. Sanger's Home for Chronic And Aged 500 West 57th Street	Mr. Robert E. Sanger	140	124
Brooklyn			
6. Beverly Nursing Home 346 Ocean Parkway	Mrs. Fannie Hoffman	25	23
7. Caton Nursing Home 150 Ocean Parkway	Mr. Arthur Pomerant	40	33
8. Clinton Nursing Home 415 Clinton Avenue	Mrs. Ruth Buckingham	15	11
9. Flatbush Kingsland Nursing Home 1101 Cortelyou Road	Mrs. E. M. Kinnean	16	16
10. Amanda Wood Nursing Home 298 Clinton Avenue	Mrs. Amanda Wood	21	19
Bronx			
11. Golden Convalescent House 787 East 176 Street	Mrs. Leah E. Golden	35	33

Bronx (Cont'd)	Licensee	Bed Capacity	Beds Occupied
12. Harriet Franck's Nursing Home 453 West 236 Street	Mrs. Agnes Von Franck	8	8
13. Melrose Manor Convalescent and Nursing Home, 783 Elton Avenue	Mr. Robert J. Heisterman	22	20
14. Parkside Convalescent Home 2886 Valentine Avenue	Mr. Louis Bornstein	28	26
15. Pragnell Nursing Home 2886 Valentine Avenue	Mrs. R. Pragnell	11	11
Queens			
16. Dury Nursing Home 110-24 Farmers Blvd., St. Albans	Mrs. Marie A. Dury	26	26
17. Woods Manor Nursing Home 171-36 109th Avenue, Jamaica	Mrs. Catherine F. Woods	15	15

Convalescent Homes

	Director	Bed Capacity	Beds Occupied
1. Irvington House Irvington-on-Hudson, New York	Mrs. Eleanor Barr	100	100
2. Schermerhorn House Milford, Connecticut	Mrs. Dorothy Doremus	128	98
3. Neustadter House Yonkers, New York	Mrs. Blanca Farhi	56	34
4. Isabella House 190th Street and Amsterdam Avenue	Mrs. Anna Von Boetticher	28	27
5. Jewish Home for Convalescents Grandview-on-Hudson, New York	Mr. Morton Berk	80	40

		Director	Bed Capacity	Beds Occupied
6.	Bikur Cholim Convalescent Home Mount Vernon, New York	Mr. Meyer Levine	78	56
7.	Hebrew Convalescent Home 3573 Brooklyn Boulevard, Bronx	Dr. Jackb L. Sable	80	80
8.	St. Eleanora's Home Tuckahoe, New York	Sister Marie Jeanne	24	22
9.	Loeb Memorial Home East View, New York	Mrs. Mary A. Creed	96	89
10.	St. Andrew's Convalescent Home 237 East 17th Street	Sister Mary Barbara	22	16
11.	St. Luke's Convalescent Home Greenwich, Connecticut	Mr. Arthur Slothower	110	76
12.	Elizabeth Milbank Anderson Home Chappaqua, New York	Mrs. Pearl W. Neil	104	84
13.	St. Francis Sanatorium for Cardc Children, Roslyn, New York	Mother Mary of Kevelaer	150	150
14.	St. Mary's Hospital for Children 405-11 West 34th Street, New York	Sister Hilary	60	60
15.	McCosker-Hershfield Cardiac Home, Inc. Hilburn, New York[1]	------	28	17

[1]Information received from Mrs. Dreyfus in New York Office.

APPENDIX B

SCHEDULE

1. Name of Home_____Type_____

   Location_____

2. Physical Sturcture (from outside building)

   a. general appearance_____

   _____

   b. brick_____ frame_____ stucco_____

   c. proches_____ sundecks_____ paved terraces_

   d. number of steps at front entrance_____

   e. amount of surrounding grounds_____

   f. condition of grounds_____

   g. shade trees_____

   h. other comments_____

   _____

   _____

   Information from Supervisor

3. Facilities

   a. dormitory facilities
      (1) total number of beds_____
      (2) number of beds occupied at present_____
      (3) number of persons per room_____
      (4) floors on which beds are found_____
      (5) size of room_____
      (6) number of windows per room_____
      (7) storage space per person: closets____drawers___
      (8) cheerful atmosphere_____
          wall coloring_____
          condition of walls_____
      (9) isolation facilities_____

   b. provisions for meals
      (1) seating capacity of dining room_____

(2) males and females together____ separated_____
(3) type of meal service_____type of dishes_____
(4) arrangement of dining room_____
(5) is atmosphere restful?_____
(6) is dining room connected to dormitories by covered passageways?_____
(7) floor locations_____
(8) properly balanced, wholesome, appetizing meals____

Typical Menus

Breakfast	Dinner	Supper

(9) service for bed patients_____
(10) provisions for special diet_____

c. provisions for recreation
(1) reading and quiet games rooms_____what floor?_____
(2) rooms for noisy games__gymnasium__what floors?____
(3) outdoor recreational facilities_____

d. provisions for entertaining guests_____

e. miscellaneous
(1) elevator service_____
(2) laundry facilities_____
(3) toilet and bathing facilities
location of toilets_____
number of toilets_____
number of tubs_____number of showers_____
(4) special services_____

4. Description of Patients

a. admittance policies_____

b. age range of present population
under 10 years_____
10 to 19 years_____
20 to 39 years_____

age range of present population (Cont'd)
40 to 59 years_____
60 years and over_____

c. number of males_____number of females_____

d. Prostetant_____Catholic_____Jewish_____

e. White_____Negro_____Other_____

f. types of cases_____
_____
_____
_____

g. average length of stay in home_____

5. Personnel

a. doctors on call_____ doctors in residence_____

Duties_____
_____
_____

b. nurses on call _____nurses in residence_____
qualifications_____
_____

c. dieticians_____training_____

d. recreational directors_____training_____

e. occupational therapists_____
description of work_____
_____
_____

6. Administrative Set-up

a. licensed by state_____licensed by city_____
b. source of funds and financial support_____
_____
fees per patient_____
d. average annual budget - income_____expenditures_____
d. how governed_____
_____
_____

e. racial policy_____
_____
reasons for this policy_____
_____
_____

f. other policies_____

g. recommendations and improvements
(1) changes in policy_____

(2) changes in physical conditions_____

BIBLIOGRAPHY

Books

Bryant, John. Convalescence Historical and Practical. New York: The Sturgis Fund of the Burke Foundation, 1927.

Corwin, E. H. Lewinski. Institutional Convalescence Standards for the Care and Management of Convalescent Homes. New York: The Sturgis Reserve Fund of the Burke Foundation, 1925.

Davis, John Eisele. Principles and Practice of Recreational Therapy. New York: A. S. Barnes and Co., Inc., 1936.

Diserens, Charles M. The Influence of Music on Behavior. Princeton: Princeton University Press, 1926.

Dunton, William Rush Jr. Occupational Therapy. Philadelphia and London: W. B. Saunders Co., 1918.

Sherman, Henry C. Food and Health. New York: The Macmillan Co., 1934.

Pamphlets and Reports

Analysis of Programs of National Urban League and Urban League of Greater New York. New York City: United Urban League Service Fund, 1946.

Bishop, Margaret K. "Study of Commercial Nursing and Boarding Homes in Philadelphia." Philadelphia: Department of Public Assistance, 1945. (Mimeographed).

Convalescent Care. Proceedings of the Conference Held Under the Auspices of the Committee on Public Health Relations of the New York Academy of Medicine. New York: The New York Academy of Medicine, 1940.

Corwin, E. H. L., and Kidner, T. B. Standards for Convalescent Homes Policy - Organization - Planning. New York: The Sturgis Fund of the Burke Foundation, 1930.

Gardiner, Elizabeth G. Convalescent Care in Philadelphia. Philadelphia: Council of Social Agencies, 1939.

Gardiner, Elizabeth G. and Thomas, Francisca K. The Road To Recovery From Illness. New York: Hospital Council of Greater New York, 1945.

Montero, Frank and Kondel, Bernice. This is New York Too! New York: Urban League of Greater New York, 1944.

Regulations Governing The Establishment and Maintenance of Private Proprietary Nursing Homes, Convalescent Homes and Homes for the Aged or for Chronic Patients. New York City: Department of Hospitals, 1942.

Rountree, Jennie I. This Problem of Food. New York: Public Affairs Committee, 1939.

"The Urban League of Greater New York, Inc. Its Background and Its Future." New York: 1944.

Ward, William. "Accommodations in Licensed Commercial Nursing Homes in Philadelphia." Philadelphia: Council of Social Agencies, 1944. (Mimeographed).